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Philip G. Peters Jr.

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# Resuscitating Hospital Enterprise Liability

Philip G. Peters, Jr. \*

## I. INTRODUCTION

No tort reform has more potential to improve the quality of medical care and to reduce the frequency of patient injuries than exclusive hospital enterprise liability. Hospital enterprise liability would make hospitals liable for all patient injuries occurring in the hospital that are the product of provider negligence, regardless of the independent contractor status of the providers. In its “exclusive” form, enterprise liability would also eliminate the personal liability of individual physicians and nurses.

Exclusive hospital liability is also more likely than any other even-handed tort reform to reduce the extraordinary fear and anger that the threat of malpractice liability engenders in practicing physicians. As a result, the disappearance of enterprise liability from current discussions of malpractice reform is a serious mistake.

Medical errors are far too common.<sup>1</sup> Yet, medical malpractice law--the body of law intended to reduce these errors--is widely believed to have failed in its deterrent role.<sup>2</sup> Critics base this conclusion on three contentions. First, research studies have been unable to detect a significant deterrent effect on the frequency of medical errors. Second, physicians do not believe that providing high quality medical care will shield them from malpractice liability. As long as they believe that tort law operates this way, then the threat of tort liability is unlikely to prompt improvements in patient safety. Third, patient safety advocates regularly complain that medical malpractice law poses a serious obstacle to the reduction of medical errors because it makes physicians afraid to discuss them.

Exclusive hospital enterprise liability has the potential to revive the dormant deterrent power of tort law. The reasons are simple. Unlike individual physicians, hospitals are experience-rated repeat players who have the vantage point and the resources needed to recognize and implement systematic improvements in the process of delivering health care. Adoption of enterprise liability would align the incentives of tort law with the goals of modern

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\* Ruth L. Hulston Professor of Law, University of Missouri. This paper is the product of years of thinking about tort law during which I benefited immeasurably from the guidance and input of my colleague and friend, David Fischer. David, this one's for you.

1. Elliott S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, HEALTH AFF., Dec. 5, 2006, at W44, <http://content.healthaffairs.org/cgi/content/abstract/26/1/w44>.

2. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1608-09 (2002).

patient safety advocates who emphasize the need to shift our focus from the blaming of individual wrongdoers to the design of systems that anticipate and prevent human error. Exclusive enterprise liability would also reduce the disruption caused by the insurance cycle, spare high-risk specialists from shouldering a disproportionate share of health care's liability costs, reduce litigation costs that arise in multi-defendant lawsuits, and dampen the extraordinary anger of practicing physicians. The time has come to adopt hospital enterprise liability.

Part I of this Article explains why existing malpractice law has failed to make patients safer. Part II then reviews the history of proposals for enterprise liability and the reasons those proposals were not adopted. Part III outlines my contention that hospital enterprise liability would revive the deterrent power of medical malpractice law. It also defends my claim that enterprise liability would align tort law with efforts of modern patient safety experts to reduce errors by focusing on system-wide improvement, rather than individual blame. Finally, it explains how this reform would advance the recommendations of health reformers who want to improve the quality and cost-effectiveness of health care by making health care systems more accountable for these outcomes. They, too, place great emphasis on hospital level accountability. Part IV then explores the many benefits that enterprise liability is likely to confer which are not related to patient safety. Part V reviews several possible weaknesses of enterprise liability. In the Conclusion, I argue that the strengths of exclusive hospital enterprise liability substantially outweigh those weaknesses.

## II. THE LACK OF DETERRENCE FROM INDIVIDUAL PHYSICIAN LIABILITY

Scholars have long lamented the failure of malpractice law to send a coherent deterrent signal to physicians. They base this conclusion on two facts. First, research studies have been unable to find any evidence that the current system of individual liability reduces the frequency of medical negligence.<sup>3</sup> Second, physicians do not believe that they are shielded from malpractice liability by practicing higher quality medicine.<sup>4</sup> As long as the recipients of the tort signal interpret it in this fashion, the threat of tort liability will not encourage safer practices.

Despite three decades of debate and several substantial studies, no reliable evidence of malpractice law's deterrent effect has been found.<sup>5</sup> To some

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3. See *supra* text accompanying note 2.

4. See Mello & Brennan, *supra* note 2, at 1619 (discussing the "incredibly small overlap between the group of patients injured by negligence and the group who brought suit").

5. *Id.* at 1607 ("There is little evidence of true error deterrence stemming from medical malpractice liability.").

extent, the absence of confirmatory evidence may simply reflect the methodological difficulties involved in trying to detect it. Nevertheless, it is disappointing that none of the studies have found clear evidence of a beneficial effect on patient safety.<sup>6</sup>

Several plausible explanations for this lack of evidence have been suggested. First, the liability insurance purchased by physicians has not traditionally been experience-rated.<sup>7</sup> Individual physicians simply do not have sufficient exposure to litigation to make their past experience a statistically meaningful predictor of future experience.<sup>8</sup> As a result, the amount they pay in premiums is not tied to the quality of care they provide; safer practice provides no concrete reward. Second, only two to three percent of patients who are injured by medical negligence bring a lawsuit.<sup>9</sup> This widespread underclaiming greatly dilutes the legal incentive to adopt best practices. Third, the case-by-case nature of tort law adjudication arguably fails to provide physicians with clear *ex ante* guidance about which clinical practices will satisfy the legal standard of care.<sup>10</sup> Fourth, as Tom Baker argues, the volatility in premiums introduced by the insurance cycle is likely to obscure the deterrent signal that tort law might otherwise deliver.<sup>11</sup> Premiums rise sharply at seemingly random moments that lack any correlation to changes in either medical error or medical claims. Good and bad physicians suffer alike. Finally, most physicians think that patients' claims are a largely random event.<sup>12</sup> As long as they believe that good care is no less likely than poor care to lead to a malpractice claim when the patient's outcome is bad, they are unlikely to respond to tort law in a rational way.

Patient safety advocates have even claimed that medical malpractice law is currently an obstacle to improving patient safety.<sup>13</sup> They point out that modern quality improvement programs have been most effective when they stop blaming individuals within an organization for problems and, instead, design organizational processes that prevent mistakes from happening. These safer processes can only be designed when the participants are willing to

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6. *Id.* at 1607-13.

7. *Id.* at 1616 (noting that experience-rating is rare for individual physicians because claims are too stochastic to be a credible indicator of physician quality or risk).

8. *Id.* at 1618-19. In addition, the combination of very low claims rate among people with valid claims and a high number of baseless claims sends a distorted deterrence signal to provider. *Id.* at 1620. Moreover, insufficient claiming produces insufficient internalization by physicians of the damages caused by poor medicine. *Id.*

9. *Id.* at 1618-19.

10. See Michelle M. Mello et al., "Health Courts" and Accountability for Patient Safety, 84 MILBANK Q. 459, 469 (2006).

11. TOM BAKER, THE MEDICAL MALPRACTICE MYTH 45 (2005).

12. See *supra* note 9.

13. See generally COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000); PAUL WEILER, MEDICAL MALPRACTICE ON TRIAL (1991).

openly talk about the points in the treatment process at which errors and near misses are most common.<sup>14</sup>

In its exhaustive and crucial study of medical mistakes, *To Err is Human*,<sup>15</sup> the Institute of Medicine concluded that medicine would not enjoy the degree of disclosure necessary for substantial improvements in patient safety until practicing physicians were certain that their disclosures could not be used against them by tort plaintiffs.<sup>16</sup> Today, fear of malpractice liability stops physicians from discussing errors openly.<sup>17</sup> Their perception that tort liability is random also makes it hard to convince physicians that safer systems will pay off in less frequent liability.<sup>18</sup> As a result, important patient safety advocates, like Troyen Brennan and the Institute of Medicine, have concluded that malpractice reform is a predicate to fundamental improvements in patient safety.

To rebut this gloomy scenario, supporters of the current civil adjudication system often point out that error rates have dropped dramatically in anesthesiology since a major patient safety initiative was instituted by leaders in the field.<sup>19</sup> A decade ago, a major effort to reduce the number of patient injuries caused by anesthesia was spurred by high accident rates and correspondingly high malpractice premiums. The effort produced dramatic improvements in patient safety, dropping premiums from among the highest in medicine to among the lowest.<sup>20</sup>

However, the revolution in anesthesiology stands out as atypical. No other specialty has reported a similar transformation. Furthermore, it appears to have occurred when Harvard took over the purchasing of liability insurance for its physicians. After this change, physicians were no longer financially responsible for the liability costs associated with their errors. Instead, that risk was shifted to their hospital. Once it accepted those risks, it has a strong incentive to reduce the frequency of patient injuries caused by its staff. Because its anesthesia departments attracted an especially high number of claims, the hospital system began a search for safer procedures. Soon, its faculty members were researching the causes of anesthesia injury and the best ways of reducing them. Other anesthesiology researchers joined the effort

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14. Mello et al., *supra* note 10, at 472 (“[H]onesty about potential problems will both promote overall discussion and reiterate to the professional that the patient’s well-being is the first objective.”)

15. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *supra* note 13.

16. *Id.* at 87.

17. *Id.* at 109-10.

18. See WEILER, *supra* note 13, at 129.

19. John H. Eichhorn et al., *Standards for Patient Monitoring During Anesthesia at Harvard Medical School*, 256 JAMA 1017, 1019-20 (1986).

20. See David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 918-20 (2005) (describing the history of anesthesia quality improvement).

and remarkable improvements in medical safety resulted. Thus, the success in anesthesiology illustrates how organizational or “enterprise” liability can spur safety improvements that simply do not occur when the system leaves every man or woman to fend for herself.

### III. A BRIEF HISTORY OF HOSPITAL ENTERPRISE LIABILITY

In most areas of commerce, a business enterprise is legally liable for the carelessness of any worker who is carrying out its activities.<sup>21</sup> In fact, it is rare for accident victims to sue the workers individually. That paradigm usually applies to both unskilled workers, like custodial crews, and to highly-skilled workers, like airline pilots, even though airline managers cannot realistically oversee the decisions made by pilots in the field. Thus, a shopper who slips on a broken pickle jar in the grocery store typically sues the store, not the janitor, even though she is entitled to sue both. The lawyer for a homeowner who is injured by a defective weed-eater would not even consider suing the assembly line worker whose mistake caused the malfunction. She would sue the manufacturer and the retailer instead.<sup>22</sup> As a result, liability for individual error is never born exclusively by the person who made the error. Instead, legal accountability is shifted entirely to the larger business entity.

That has never been true in health care. All community-based physicians, like internists and surgeons, and many hospital-based physicians, like radiologists, are treated as independent contractors, rather than agents or employees of the hospital.<sup>23</sup> As a result, hospitals are not ordinarily vicariously liable for the negligence of treating physicians.

Physicians have long preferred this arrangement because it offers the advantage of independence from hospital oversight.<sup>24</sup> In 1965, when the famous *Darling* case threatened to reduce that independence by imposing a duty of hospital oversight,<sup>25</sup> physicians were greatly alarmed.<sup>26</sup> But the Illi-

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21. See, e.g., DAN B. DOBBS, *THE LAW OF TORTS* 910-17 (2000) (explaining that the negligence must occur within the scope of employment).

22. In my experience as a tort defense attorney, in the rare instances when individual workers are named in the lawsuit, their employer routinely represents them and holds them harmless.

23. See BARRY R. FURROW ET AL., *HEALTH LAW* 376-77 (1995) (describing the traditional independent contractor relationship). Some, but not all, states have begun to impose vicarious liability on hospitals for the conduct of physicians who are exclusively hospital-based and who are selected by the hospital, rather than the patient, such as many emergency medicine doctors and anesthesiology departments, using a theory of ostensible or apparent agency. *Id.* at 377-80. However, that legal theory won’t support liability for the torts of physicians who are chosen by patients outside of the hospital. *Id.* at 378.

24. 2 AM. LAW INST., *REPORTER’S STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY* 125-26 (1991).

25. *Darling v. Charleston Cmty. Mem’l Hosp.*, 211 N.E.2d 253 (Ill. 1965).

nois Supreme Court was too far ahead of its time, and the courts of that state soon watered down the language of that decision.<sup>27</sup>

Physicians also defeated the next serious threat to their legal independence. It arose in 1991 and came from the academy, rather than the courts. At that time, a Reporter's Study for the American Law Institute (ALI) suggested that the current system of malpractice adjudication be replaced with a no-fault system in which hospitals, rather than individual physicians, would be exclusively liable for injuries occurring within the hospital.<sup>28</sup> Written by Paul Weiler, this report built upon the scholarship of Havighurst, Tancredi, Keeton, and O'Connell, who had proposed medical no-fault plans in the early 1970s.<sup>29</sup>

The ALI plan had several appealing characteristics. One was elimination of the need to charge an individual physician with incompetence. This change brought with it the realistic possibility that physicians would no longer be the most passionate opponents of effective legal redress for injured patients. Reduction of this anger would also allow physicians to stop looking over their shoulders and devote more attention to the task of improving patient safety. The plan was also intended to improve the quality of medical care by giving hospitals the incentive to adopt organization-wide safety precautions.<sup>30</sup>

Weiler was also part of the research team that carried out the famous Harvard Study of Medical Practice in New York. They, too, endorsed a combination of no-fault recovery and exclusive hospital enterprise liability.<sup>31</sup> Several faculty members from the Harvard School of Public Health were on that team, and they continued to push for these reforms throughout the next

26. MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS* 462-63 (7th ed. 2007) (noting "the vocal reaction of hospitals and physicians").

27. See, e.g., *Pickle v. Curns*, 435 N.E.2d 877 (Ill. App. Ct. 1982); HALL ET AL., *supra* note 26, at 464 (noting that "subsequent decisions in Illinois have expressly disavowed any such duty arising from *Darling*").

28. See 2 AM. LAW. INST., *supra* note 24.

29. See, e.g., Clark C. Havighurst & Lawrence R. Tancredi, "Medical Adversity Insurance" – A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 MILBANK Q. 125, 125-26 (1973); Robert E. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 616-17 (1973); Jeffrey O'Connell, *Expanding No-Fault Beyond Auto Insurance: Some Proposals*, 59 VA. L. REV. 749, 827 (1973).

30. 2 AM. LAW INST., *supra* note 24, at 123 ("the best vehicle for identifying and dealing with such incidents is the organization in which the doctor practices").

31. HARVARD MED. PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 11-9 (1990). That team included two Harvard scholars who had helped write the earlier ALI study. Paul Weiler, a Harvard law professor, was both the Chief Reporter of the ALI Report and the senior legal investigator on the Harvard Study. Troyen Brennan, a faculty member at the Harvard Schools of Medicine and Public Health, also served on both projects.

decade.<sup>32</sup> Because the benefits of enterprise liability far outweigh its disadvantages, many respected health law scholars endorsed it. They include Clark Havighurst,<sup>33</sup> Paul Weiler,<sup>34</sup> Troyen Brennan,<sup>35</sup> Michelle Mello,<sup>36</sup> David Studdert,<sup>37</sup> Tom Baker,<sup>38</sup> and William Sage.<sup>39</sup> Although these scholars differed on a number of issues, like the choice between hospitals and managed care organizations as the responsible “enterprise,” they agreed on the need for institutional, rather than individual, responsibility. They shared the belief that health care quality would improve if organizations had a legal incentive to minimize medical accidents.<sup>40</sup> In hindsight, the Illinois Supreme

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32. Faculty members Troyen Brennan, Joseph Newhouse, Lucian Leape, and David Studdert have written extensively on the subject, including the following: PAUL C. WEILER ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION* (1993); Joseph P. Newhouse & Paul C. Weiler, *Reforming Medical Malpractice and Insurance*, 14 REG. 78 (1991); William G. Johnson, Troyen A. Brennan, Joseph P. Newhouse, Lucian L. Leape, Ann G. Lawthers, Howard H. Hiatt & Paul C. Weiler, *The Economic Consequences of Medical Injuries: Implications for a No-Fault Insurance Plan*, 267 JAMA 2487 (1992); David Studdert & Troyen Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217 (2001); David M. Studdert, Eric J. Thomas, Brett I. W. Zbar, Joseph P. Newhouse, Paul C. Weiler, Jonathan Bayuk & Troyen A. Brennan, *Can the United States Afford a “No-Fault” System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1 (1997); David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of “No-Fault” Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225 (2001); Paul C. Weiler, Joseph P. Newhouse & Howard H. Hiatt, *Proposal for Medical Liability Reform*, 267 JAMA 2355 (1992).

33. Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J. L. & MED. 7, 8 (2000) (advocating vicarious liability for managed care plans).

34. Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 381 (1994); WEILER, *supra* note 13, at 114.

35. Mello & Brennan, *supra* note 2, at 1598.

36. *Id.*

37. *See supra* note 31.

38. BAKER, *supra* note 11, at 164-65 (recommending that hospitals be obliged to purchase “enterprise insurance” covering all claims against medical providers using hospital facilities). Baker believes that doctors and hospitals might more readily accept enterprise insurance than enterprise liability because formal liability is resisted by physicians. *Id.*

39. William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J. L. & MED. 1, 1-2 (1994) (advocating vicarious liability for managed care plans).

40. *See also* Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1979, 1988 (2003) (using economic analysis to show that managed care organizations should be vicariously liable even if they do not exert direct control over physicians).



Court's initial decision in *Darling* suggesting the need for greater hospital oversight had been right all along.

However, the efforts of these reformers bore no fruit. Health care organizations and lawmakers were leery of the potential costs of a no-fault liability regime. As a result, not even a small scale pilot experiment took place.

Believing that no-fault liability was simply not politically feasible, the Harvard public health team dropped the idea in 2002.<sup>41</sup> However, its members continued to support exclusive enterprise liability because it has more potential than any other tort reform to produce improvements in patient safety.<sup>42</sup> In 2006, they shifted their support to an alternative reform proposal—administrative health courts—that contains neither no-fault liability nor hospital enterprise liability.

Yet, the case for exclusive hospital liability has never been stronger. In fact, ongoing changes in the medical industry have simultaneously strengthened the arguments in favor of hospital vicarious liability, while also increasing the odds that this overdue reform will meet a more tolerant audience in the medical community than it has in the past. Many things have changed since the first proposals for enterprise liability were made. Most importantly, the evolution of the medical industry and the rise of the modern patient safety movement have materially changed the social and economic context in which enterprise liability must be evaluated. In addition, we have gathered data and experience during the intervening years that need to be taken into account. These events justify a fresh analysis.

#### IV. IMPROVED PATIENT SAFETY

The most important reason to favor enterprise liability is its potential to reduce medical negligence. In this important respect, hospital enterprise liability is far superior to the traditional rules of malpractice liability, which emphasize individual legal liability over organizational liability. Despite three decades of attention, there is still no systematic evidence that these rules have a beneficial deterrent effect.

Enterprise liability has the potential to be far more effective because it will shift responsibility onto actors with greater organizational and financial ability to reduce medical errors and generally improve patient safety and a more tangible reason to use that capacity. Unlike individual liability, enterprise liability would give hospitals a substantial legal incentive to effectuate these changes. The availability of liability insurance would not eliminate this incentive because hospital policies, unlike physician policies, are typically experience-rated.

At the same time, hospitals have greater capacity than individual physicians to respond to this incentive productively. Hospitals have a far better

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41. Mello & Brennan, *supra* note 2, at 1625, 1628.

42. *Id.* at 1629.

ability to see the “big picture” than individual providers do. This organization-wide perspective places the hospital in the optimal position to identify and put into place cost-effective safety improvements, especially when those improvements cross the boundaries of individual physician practice, specialty or department, and the professional divide that separates doctors, nurses, and health-related professions. Finally, hospitals are much more likely to possess the resources needed to effectuate system-wide reform.

### A. Experience Rating

Unlike individual physicians, hospitals pay insurance premiums that are adjusted to reflect their payout experience.<sup>43</sup> As a result, enterprise liability would impose a stronger financial incentive to reduce errors on hospitals than the current legal regime places on individual physicians. In the field of workers’ compensation insurance, experience-rating of employers has reduced the number of workplace fatalities by more than twenty five percent.<sup>44</sup> Hospital vicarious liability has the potential to provide patients with similar benefits.

### B. Superior Resources

Two respected health policy researchers, Michelle Mello and Troyen Brennan, put it bluntly. “[O]nly institutions can muster the resources to bring about systematic improvements in patient safety.”<sup>45</sup> Most physicians work in solo or small group practices and lack the necessary resources to develop new information systems, care management protocols, or ongoing quality improvement initiatives.<sup>46</sup> To the extent that hospital systems have the necessary resources, enterprise liability would give them an incentive to use them.

In other industries, the safety incentives imposed by organizational liability have helped prompt the extraordinarily successful use of modern quality improvement theory with its emphasis on systems design, rather than indi-

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43. 2 AM. LAW INST., *supra* note 24, at 123-24; Mello & Brennan, *supra* note 2, at 1617-18, 1633. While hospitals currently bear some of the costs of iatrogenic injury, enterprise liability would substantially increase those costs. Michelle M. Mello et al., *Who Pays for Medical Errors? An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for Patient Safety Improvement*, 4 J. EMPIRICAL LEG. STUD. 835 (2007) (abstract) (finding that hospitals bear only twenty-two percent of the costs generated by iatrogenic injuries).

44. 2 AM. LAW INST., *supra* note 24, at 506-07 (citing MICHAEL J. MOORE & W. KIP VISCUSI, *COMPENSATION MECHANISMS FOR JOB RISKS: WAGES, WORKERS’ COMPENSATION, AND PRODUCT LIABILITY* 133-35 (1990)); see also JOSEPH V. REES, *REFORMING THE WORKPLACE: A STUDY OF SELF-REGULATION IN OCCUPATIONAL SAFETY* 72-80, 114-18 (1988) (offering a case study in the influence of worker’s compensation premiums and employer safety policy).

45. Mello & Brennan, *supra* note 2, at 1623.

46. Fisher et al., *supra* note 1, at W53.

vidual fault. Using this approach, both the aviation and automobile industries have shifted their focus from individual workers to the entire system of production and delivery. This has led them to identify and develop system-wide strategies to analyze error data, to collect better data, to examine high risk settings like hand-offs from one provider to another and multi-person processes, and to anticipate and prevent foreseeable human errors.<sup>47</sup>

Each of these industries operates under the incentives of a system in which the enterprise bears all of the costs of legal liability. As noted by the ALI Report, “[N]o-one expects that the pilots or machinists working for an airline firm would personally pay a substantial premium for insurance against their own instances of careless behavior.”<sup>48</sup> By contrast, three-quarters of all malpractice claims are brought against individual health care providers.<sup>49</sup>

### C. Capacity to Oversee a Complex System

As safety advocates routinely point out, health care organizations are in a far better position than individual providers to see opportunities to improve patient safety and to act on those insights. Enterprise liability would provide them an incentive—now absent—to use that vantage point to improve patient safety.

Sadly, physicians too often cling to the traditional belief that errors are the fault of individuals, rather than systems, and that safety is best improved by eliminating incompetent providers, rather than improving the systems in which they work.<sup>50</sup> By contrast, experts in patient safety believe that major advances in patient safety are far more likely to come by studying and improving the processes through which health care is delivered.<sup>51</sup> Because a large portion of the errors that occur are due to system breakdowns,<sup>52</sup> the experts persuasively argue that much more attention needs to be given to the identification and improvement of the points in the system where errors are most common and less to the individuals who make the errors. Then hospitals could redesign those weak stages so that foreseeable mistakes are prevented, or they are detected before serious harm results. While hospitals and their committees have the capacity to examine the entire delivery system in this fashion, individual physicians do not. William M. Sage offers this assessment: “The likely solution [to excessive medical error] is reducing frag-

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47. Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1855 (1994) (discussing the aviation industry).

48. 2 AM. LAW INST., *supra* note 24, at 118 n.14.

49. *See id.* at 115.[citing 1984 Closed Claims Survey at 52-53]

50. *See* Thomas H. Gallagher et al., *US and Canadian Physicians' Attitudes and Experiences Regarding Disclosing Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1605, 1610 (2006) (finding that 50% of physicians deny that systemic errors cause most medical errors).

51. *See* Mello & Brennan, *supra* note 2, at 1623.

52. *See id.*

mentation and improving coordination of care through a greater institutional role in both liability risk-bearing and clinical practice. In other words, the solution is enterprise liability.”<sup>53</sup>

Even when an injury appears to have been caused by an individual error, prevention of similar injuries in the future is often best accomplished by changing the system or environment in which individual doctors and nurses work. For example, systemic changes, like augmenting the size of the workforce during periods of heavy workload and requiring that a second physician confirm an initial diagnosis or test interpretation in pre-selected circumstances associated with high error rates, are promising ways of preventing individual errors and protecting patients from common sources of injury.<sup>54</sup> By contrast, individual physicians possess much less capacity than hospitals to recognize weaknesses in the overall system of delivery and to correct those weaknesses, thereby reducing errors and injuries.<sup>55</sup> Of course, this is the central claim of modern patient safety advocates. As a result, most experts believe that hospitals are better situated to improve patient safety than individual physicians.

Furthermore, hospital enterprise liability is consistent with models favored by legal economists, like Guido Calabresi, who recommend that the law impose liability on the party best positioned to recognize risks and to take appropriate measures to prevent them.<sup>56</sup> He called parties in this position “the cheapest . . . cost avoiders.”<sup>57</sup> Hospitals play this role in the delivery of in-patient health care.<sup>58</sup>

Leading experts in medical quality improvement also want responsibility for quality placed on hospitals. Elliott Fischer, a physician and policy expert at Dartmouth, puts it this way:

Because most patients receive their care within the context of a local delivery system comprising physicians and the hospital where they work, the hospital and its extended medical staff provide a

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53. William M. Sage, *Medical Malpractice Insurance and the Emperor's Clothes*, 54 DEPAUL L. REV. 463, 479 (2005).

54. Allen Kachalla et al., *Missed and Delayed Diagnoses in the Emergency Department: A Study of Closed Malpractice Claims From 4 Liability Insurers*, 49 ANNALS OF EMERGENCY MED. 196, 203 (2007).

55. Sage, *supra* note 52 at 478 (citing COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *supra* note 13, at 49-68) (describing why errors occur).

56. See generally GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* 135-73 (1970) (advocating liability on the parties, given transaction costs, who are best situated to control quality).

57. *Id.* at 135 n.1.

58. There is limited empirical evidence suggesting that hospitals are more responsive than physicians to the deterrence signals transmitted by tort law. See Troyen A. Brennan, *The Role of Regulation in Quality Improvement*, 76 MILBANK Q. 709, 721 (1998) (reporting “a deterrent effect in analyses of hospitals but not of individual physicians”).

natural organizational setting within with to improve the overall experience of care. Policy initiatives should be judged at least in part on the degree to which they strengthen accountability and collaboration at the level of the hospital and its medical staff.<sup>59</sup>

Placing accountability for quality primarily on hospitals, rather than individual physicians, confers an additional advantage. Hospital outcome data provides a more defensible basis for assessing provider performance than data gathered at the level of individual departments or physicians.<sup>60</sup> Sample sizes will be larger, the administrative complexity of data management will be less daunting, and physicians may be less resistant to the collection of this data.<sup>61</sup>

As a result, hospital level accountability plays a central role in most proposals for greater scrutiny of medical outcomes. The ability of hospitals to assume the central role in quality improvement is, thus, crucial to the success of ongoing initiatives to rate provider performance ("report cards") and to reward quality with enhanced reimbursement ("pay for performance"). Accordingly, a state-by-state movement toward hospital enterprise liability would better align tort law with the goals of the industry's own experts on quality improvement.

Placing primary accountability at the hospital level would also facilitate industry efforts to reward greater cost-consciousness. Currently, hospitals and physicians can often increase their profits by making decisions that increase utilization, capacity, and ultimately the cost to patients and their health insurers. As a result, clinical practices in U.S. hospitals often include far more physician visits, specialist consultations, inpatient admissions, and diagnostic tests than are justified by the medical benefit.<sup>62</sup> Accountability systems that track hospital costs and quality over time will reward hospitals which resist these temptations and invest, instead, in measures proven to reduce errors, like better care management systems, stricter hand-washing protocols, and electronic medical records. These practices do not reduce costs, but they improve quality.<sup>63</sup> As a result, Medicare is currently undertaking demonstration projects to study payment systems that reward improved performance at the level of the hospital and its medical staff.<sup>64</sup>

Other areas of tort law already recognize the wisdom of placing primary legal responsibility for the quality of services and products on the business enterprise that produces them, rather than the individuals who make or deliver them. For unique historical reasons, medical malpractice law has long been

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59. Fisher et al., *supra* note 1, at W55-56.

60. *Id.* at W49.

61. *Id.* at W52.

62. Fisher et al., *supra* note 1, at W53-54; John E. Wennberg & Philip G. Peters, Jr., *Unwarranted Variations in the Quality of Health Care: Can the Law Help Medicine Provide a Remedy/Remedies*, 37 WAKE FOREST L. REV. 925, 930-32 (2002).

63. Fisher et al., *supra* note 1, at W53.

64. *Id.* at W55.

an exception to that model. The time has come to revisit that exception. Modern health care is far more complex than it was when the original medical malpractice rules were adopted. In its infancy, medicine was practiced by solo practitioners, and hospitals were just places where the poor went to be quarantined or to die. Today, health care is delivered by large teams of highly-trained individuals in a complex web of interactions that demands coordination and oversight.<sup>65</sup> The industry's own experts on patient safety have recognized that new reality; it is time for tort law to do so as well.

#### *D. Improved Physician Willingness to Disclose Errors*

Physicians are notoriously reluctant to engage in the open discussion of errors and near misses needed to identify the sources of medical error and to design systems that prevent the errors.<sup>66</sup> That reluctance is likely to soften if malpractice liability is born exclusively by hospitals or similar health care organizations.

This change in malpractice law will help hospitals create "blame free" cultures that encourage open discussion of errors. As long as physicians remain at risk of individual malpractice liability, they can legitimately scoff at the notion that disclosure will be "blame free." Exclusive enterprise liability would loosen physician resistance not only by enabling hospitals to create blame-free cultures, but also by removing the specter of individual tort liability. Today, just the filing of a lawsuit creates a "record" that follows physicians for their professional lifetimes, re-opening like a scab every time their hospital privileges are renewed or they apply for liability insurance or a medical license.

Furthermore, exclusive enterprise liability advances the goal of greater disclosure and improved physician morale without depriving negligently injured patients of the redress to which they are entitled.<sup>67</sup> As a result, it is far superior to many reforms that are popular with physicians, such as draconian caps on damages and confidentiality laws that place hospital records beyond the reach of injured patients.

However, it is important not to overstate the extent to which enterprise liability would open the gates of physician disclosure. Disclosure of error is a painful event in the life of any professional. Merely acknowledging the error to oneself is painful. Revealing it to peers is much more difficult. Research

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65. Michelle M. Mello et al., *Hospitals' Behavior in a Tort Crisis: Observations from Pennsylvania*, 22 HEALTH AFF. 225, 232 (2003) (stating that hospitals are best positioned and "most responsible for the quality of hospital-based services").

66. See Philip G. Peters, Jr., *Health Courts?*, 88 BOSTON U. L. REV. 227, 277 (2008).

67. See Randall R. Bovbjerg, *Reform of Medical Liability and Patient Safety: Are Health Courts and Medicare the Keys to Effective Change?*, 9 J. HEALTH CARE L. & POL'Y 252, 254 (2006) (observing that the usual plea for "blame free" quality enhancement ignores the legitimate expectations of injured patients).

has shown that physicians have great difficulty recognizing their own errors and even more difficulty disclosing them to others.<sup>68</sup> Errors threaten their self-esteem and expose them to loss of reputation and authority in the eyes of their peers and patients.<sup>69</sup> As a result, U.S. physicians were reluctant to disclose or discuss errors even before the growth of malpractice litigation in the 1960s.<sup>70</sup> And physicians in countries with much lower litigation rates also balk at open discussion of error.<sup>71</sup> While fear of malpractice liability may exacerbate the preference for secrecy, it did not create it. That makes it unwise to predict exactly how much additional disclosure will take place after a state adopts exclusive enterprise liability.

Nevertheless, it seems reasonable to predict that the removal of individual legal responsibility will make, at the very least, a measurable difference in physician openness. This reform will eliminate many of the professional penalties that arise merely from being publicly named in a lawsuit, regardless of its merits, such as embarrassment, risk to reputation, reporting of all settlements to the National Practitioner Data Bank, and disclosure on applications for admitting privileges, board certification, and liability insurance. As a result, it is fair to assume that enterprise liability will materially improve physician participation in patient-safety initiatives.

### *E. Patient Outcomes—Some Evidentiary Clues*

In theory, enterprise liability has extraordinary potential to spur improvements in patient safety. Will it fulfill that promise? At present, the evidence is largely circumstantial. Most exciting is the transformation that occurred in anesthesiology in response to the prompting of a hospital system's risk managers.

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68. See, e.g., Ralph Peeples, Catherine T. Harris & Thomas B. Metzloff, *Settlement Has Many Faces: Physicians, Attorneys, and Medical Malpractice*, 41 J. HEALTH & SOC. BEHAV. 333, 341 (2000).

69. Thomas H. Gallagher et al., *Choosing Your Words Carefully*, 166 ARCHIVES INTERNAL MED. 1585, 1585 (2006).

70. See Mello et al., *supra* note 10, at 473.

71. Canadian physicians, for example, are "sued approximately one quarter as frequently" as American doctors. Thomas H. Gallagher et al., *US and Canadian Physicians' Attitudes and Experiences Regarding Disclosing Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1605, 1606 (2006). Yet, Canadian physicians are only somewhat more supportive of disclosing serious errors to patients than U.S. physicians are. *Id.* at 1609. They are no more likely to report having actually disclosed any serious error. *Id.* at 1605, 1607. The researchers concluded that "US tort reform, while potentially desirable for other reasons, may have limited effect on physicians' disclosure attitudes and practices" because "the malpractice environment may not be the major determinant" of physician reluctance to disclose. *Id.* at 1609. Instead, disclosure practices "may relate to the norms, values, and practices that constitute the culture of medicine." *Id.*

Accident rates in anesthesiology dropped miraculously at the end of the twentieth century. Events at Harvard's hospitals apparently helped trigger the transformation. All the anesthesiologists at Harvard's nine hospitals were insured by Harvard's malpractice insurance plan.<sup>72</sup> Because malpractice payouts for anesthesiology were very high, the plan's risk managers asked the hospital's anesthesiologists to investigate why their collective experience was so poor.<sup>73</sup> They responded in the academic way you might expect, and a generation of literature reviews and new studies followed. That led to the creation of new techniques and equipment that materially reduced the risk of patient injury.<sup>74</sup> Mortality rates dropped from 1 in 10,000-20,000 to 1 in about 200,000, a ten- to twenty-fold improvement.<sup>75</sup> Premiums dropped from the top echelon of the medical profession to the bottom.<sup>76</sup> This transformation was caused in significant part by the incentive that Harvard's system of de facto enterprise liability imposed on its organizational budget. Having insured its physicians, Harvard had a strong incentive to reduce the cost of that insurance.

Of course, the merits of enterprise accountability cannot be established with a single case study. After all, similar transformation did not occur in Harvard's other high-risk departments. Nor have they been initiated at hospitals that lack the research capacity of Harvard. Nevertheless, a number of clues suggest that patient outcomes will improve if enterprise liability becomes more common.

One of them is provided by a 2007 study of errors in the emergency department.<sup>77</sup> In it, Allen Kachalia and his colleagues identified the most common sources of diagnostic error in the ER. In their discussion of these findings, they suggested several ways to reduce these errors. Every one of these

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72. See generally Eichhorn et al., *supra* note 19.

73. *Id.* at 1017.

74. *Id.* at 1018-20. At the same time, high malpractice premiums and bad publicity prompted the American Society of Anesthesiologists to do an intensive study of the causes of anesthesia-related injuries and to develop better protocols. See Hyman & Silver, *supra* note 20, at 919-20 (describing the history of anesthesia quality improvement). The improved standards and tools that resulted from these combined efforts have since become standard across the country. Leape, *supra* note 46.

75. Hyman & Silver, *supra* note 20, at 918.

76. *Id.* at 918-20.

77. See Kachalla et al., *supra* note 53, at 196. In addition, studies from the Dartmouth Atlas investigators have found that hospitals with lower risk-adjusted mortality rates and lower costs were more tightly affiliated with their medical staffs. Fisher et al., *supra* note 1, at W51. However, the implications of these findings are unclear because affiliation was measured by the percent of a physician's work performed within her primary hospital. See *id.* The study did not directly measure the outcomes of hospitals which hire their physicians as employees or the hospitals which provide liability insurance for their physicians. In addition, the published study did not indicate whether care quality alone was correlated with integration.



proposed strategies called for an improvement in departmental systems, rather than greater attention to individual talent, training, or discipline.

The study found that almost every misdiagnosis involved a *combination* of individual cognitive error and a system weakness. The system failures included breakdowns in supervision, problems in the handoff occurring at a shift change, transfers of a patient from one primary care physician to another and back, failures of test results to reach the proper clinician, and excessive workload.<sup>78</sup> To reduce these errors, the authors recommended a number of changes in emergency department procedures, such as more frequent direct communication between radiology or pathology clinicians and the ordering physician and the adoption of standardized handoff procedures.<sup>79</sup> The relevance of the system breakdowns to hospital liability is obvious.<sup>80</sup>

However, the study's authors concluded that even the individual cognitive mistakes call for a systemic response. The most frequent individual error was the failure to order appropriate tests. The two essential ingredients in appropriate test ordering are accurate information and the correct application of cognitive skills. The case files reviewed in this study revealed that the latter was "particularly problematic."<sup>81</sup> Although this finding might seem to suggest that individuals, rather than systems, are the central problem, the authors concluded that the most promising strategy to reduce these errors was a systemic intervention--the adoption of explicit clinical algorithms.<sup>82</sup> They also point out that system flaws, such as excessive workloads, can themselves produce errors by individual clinicians.<sup>83</sup> Thus, systemic changes, like augmenting the staff during periods of heavy workload or requiring second opinions for the interpretation of test results in high error circumstances, offer promising ways to reduce "individual" error.<sup>84</sup> Of course, this is an essential claim of modern patient safety advocates.

Humans make errors, and the best way to prevent them is to change the environments in which they work. Enterprise liability would encourage these changes by giving the hospital a legal incentive to adopt systems that reduce the number of errors made by individuals who work within the hospital. That, of course, is precisely the same incentive that the law already delivers

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78. Kachalla et al., *supra* note 53, at 201-02.

79. *Id.* at 203.

80. Although some errors in system design or operation will make a hospital liable under current law, the patient will often find it difficult to prove that a particular policy (like excessive workload) was a cause-in-fact of the specific clinical error at the bedside.

81. Kachalla et al., *supra* note 53, at 203.

82. *Id.* at 202-03. Initially, the use of decision aids could fruitfully be targeted at the diagnoses that account for most errors. *Id.* at 202. The top three accounted for nearly half of the mistakes identified in their study. *Id.*

83. *Id.* at 203.

84. *Id.*

to business organizations in every other highly complex and potentially dangerous business industry.

The final piece of circumstantial evidence suggesting that enterprise liability will improve patient outcomes lies in the identity of the institutional leaders in the patient safety movement. Hospitals and managed care organizations which employ or insure all of their physicians already operate under a system of de facto exclusive enterprise liability. They also seem to play a disproportionate role in the most promising safety initiatives.<sup>85</sup> One example is the partnership between the Veterans Administration and managed-care giant Kaiser Permanente. Their goal is to improve the accuracy of clinical diagnoses by the development of new tools, like computer decision-support systems, to help order correct tests, institute proper follow-up plans, obtain complete medical histories, and perform adequate physical exams.<sup>86</sup> Both organizations employ their physicians and, thus, are vicariously liable for physician errors. The two leading hospitals in the push for voluntary disclosure of errors to patients also employ and insure their doctors-- the VA hospital in Lexington, Kentucky and the teaching hospital at the University of Michigan.<sup>87</sup>

Although hardly definitive, these clues are fully consistent with the common sense conclusion that exclusive hospital enterprise liability will lead to measurable improvements in patient care. Ideally, researchers would undertake a rigorous comparison of the patient outcomes in hospitals which employ and insure their physicians with the outcomes at hospitals which do not. In the absence of this data, however, lawmakers must act on the evidence that they have.

Lawmakers should recognize that hospital enterprise liability will shift legal responsibility onto actors who are better positioned to detect opportunities for safety improvement and better financed to act upon those insights. Because hospitals are experience-rated or self-insured, enterprise liability will create a greatly enhanced financial incentive to undertake those safety improvements. At the same time, the shift of liability from individual physicians to hospital systems is likely to loosen current physician resistance to promising patient safety initiatives. For all of these reasons, we urgently need to modernize the law of malpractice liability by making hospitals exclusively liable. Lives, not to mention lawsuits, literally hang in the balance.

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85. Tom Baker calls this "enterprise insurance." BAKER, *supra* note 11, at 174-78. Others call it insurance "channeling." See, e.g., WEILER, *supra* note 13, at 126; Mello & Brennan, *supra* note 2, at 1625.

86. Laura Landro, *The Informed Patient: Preventing the Tragedy of Misdiagnosis*, WALL ST. J., Nov. 29, 2006, at D1.

87. *Id.*

## V. OTHER ADVANTAGES OF ENTERPRISE LIABILITY

Enterprise liability offers several additional advantages. Although they are less dramatic than the prevention of patient injury, they are still quite significant. First, enterprise liability will temper the impact of the inevitable liability premium spikes on individual physicians. Second, hospital enterprise liability will remove the unfair penalty currently imposed on physicians who practice in a high-risk specialty, like obstetrics. Third, exclusive enterprise liability will reduce litigation costs by consolidating the defense of the hospital with the defense of its individual providers. Fourth, the elimination of individual tort liability is certain to dampen the anger of physicians and turn their attention more fully to patient care. Finally, enterprise liability will align tort law with the efforts of patient safety advocates to make hospitals more accountable for the quality and cost of medical care. Right now, physicians who are lukewarm about the shift in focus of quality improvement efforts from individuals to systems can justify their recalcitrance by citing tort law's placement of primarily legal accountability on them, rather than their hospitals. Enterprise liability would change that.

### A. *Weathering the Insurance Cycle*

Liability insurance premium levels go through periodic peaks and troughs that are called "the insurance cycle."<sup>88</sup> Although the magnitude of the peaks can be exacerbated by underlying trends in the number of claims being filed and the size of settlement payouts, the cycle itself is fueled by factors that are not related to claims experience. The cycle typically involves a period of relative stability or even shrinking of real premium levels as insurers compete on the basis of price to increase their market share and to obtain funds to invest until claims against their insureds are resolved. When changes in the investment returns, reserve levels, or legal markets warrant an increase in premiums, insurers have historically been loath to be the first to do so. As a result, corrections are delayed until price increases are essential to the company's survival. When the correction occurs, it must account for years of inappropriately low premiums. This correction of accumulated underpricing caused the sharp premium spikes that occurred in the mid-1970s, mid-1980s, and early 2000s and prompted physicians to march on state capitals across the country. It is no coincidence that the periodic escalation of angry demands for medical malpractice reform *always* follows a spike in the

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88. See TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* chap. 3 (2005) (explaining the cycle and its causes).

cycle.<sup>89</sup> Any malpractice reform that hopes to end these crises must temper the impact of these inevitable premium spikes on individual physicians.<sup>90</sup>

Exclusive liability will not moderate the cycles, but by shifting liability exclusively to hospitals, it will transfer liability to parties who are better able to buffer themselves against the disruption caused by periodic spikes in premiums. First, malpractice premiums constitute a much smaller fraction of hospital gross revenue. While liability insurance comprises over five percent of physicians' expenses, it is less than one percent of hospital revenue.<sup>91</sup> That means that spikes in insurance costs will cause less pain for hospitals than for individual physicians.

In addition, hospital systems are more able and more likely, due to their business training, to do the financial planning necessary to anticipate and survive these cycles. Existing law places this risk on the actors least able to adapt to it.

### *B. Relieving High-Risk Specialties of Their Unfair Liability Burdens*

With our current focus on individual liability, physicians who choose to practice in high-risk specialties, like obstetrics and neurosurgery, pay far more for their liability insurance than physicians in less risky specialties, like psychiatry or gerontology.<sup>92</sup> Because these doctors have chosen to work in a field where patients are often very fragile and small mistakes can be catastrophic, they pay a disproportionate share of health care's liability tax. This skewed allocation is decidedly unfair because it is wholly unrelated to the competence or carefulness of the physicians in these specialties. Physicians who practice in these high-risk specialties play a vital role in our health care system, yet they pay far higher premiums than their colleagues in lower-risk specialties.<sup>93</sup> Hospital enterprise liability can eliminate this unfair allocation

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89. 2 AM. LAW INST., *supra* note 24, at 51-52 (noting that the periodic spikes of the insurance cycle, more than any other factor, precipitated the malpractice insurance and political crises of the 1970s, 1980s, and 2001).

90. *See id.* at 67.

91. *See, e.g.,* Marc A. Rodwin et al., *Malpractice Premiums and Physicians' Income: Perceptions of a Crisis Conflict with Empirical Evidence*, 25 HEALTH AFF. 750, 751-53 (2006) (finding that premiums dropped from 11 percent of expenses in 1986 to 6 percent in 1996, but then rose to 7 percent in 2000). Testimony of Travis Plunkett, Legislative Director, Consumer Federation of America, Subcommittee on Health of the House Committee on Energy and Commerce, at 6 & Exhibit B (July 17, 2002), [http://www.consumerfed.org/pdfs/Med\\_Mal\\_House\\_testimony.pdf](http://www.consumerfed.org/pdfs/Med_Mal_House_testimony.pdf) (calculating that "malpractice premiums as a share of health costs have declined from .95 percent in 1988 to .56 percent in 2000").

92. 2 AM. LAW INST., *supra* note 24, at 116. *see also* ATIYAH, *supra* note \*, at 22-28 (noting the risk-spreading rationale for holding employers liable for torts of their employees).

93. *Id.* at 115-16.

of cost.<sup>94</sup> As noted above, this lesson was learned long ago in other industries; neither airline pilots nor fuselage welders buy their own liability insurance.<sup>95</sup>

### C. Reducing Litigation Costs

Litigation costs are rising much more rapidly than malpractice payouts are. None of the many tort reforms adopted by state legislatures during the three past malpractice insurance crises in the mid-1970s, mid-1980s, and early 2000s have staunched the climb. Exclusive hospital liability would almost certainly produce a measurable reduction of those costs.<sup>96</sup> According to one report, about twenty-five percent of all medical malpractice cases have two or more defendants.<sup>97</sup> Each defendant has his own lawyer, and each of those lawyers generates his own share of pretrial motions, discovery requests and expert witness costs. By consolidating liability exclusively in a single defendant (the hospital), exclusive enterprise liability would eliminate the multiple representation of the hospital and each of its defendant physicians by separate counsel.

### D. Dampening Physician Anger

Physicians experience the very filing of a malpractice suit against them as a form of punishment.<sup>98</sup> They also believe that this punishment is as likely to be inflicted upon the innocent as the guilty. As a result, they are bitter.

A charge of incompetence follows a physician for life, regardless of how it is resolved. As Dr. Elliot Perlman laments:

The lawyers advised me to forget it, but it's not that simple. Every year I have to fill out forms from my malpractice insurer, hospital staffs, and state licensing boards. I'm asked whether I've ever

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94. See BAKER, *supra* note 11, at 175-76 (noting that individual insurance policies place too much of the burden on physicians in high-risk specialties and high-risk locations).

95. 2 AM. LAW INST., *supra* note 24, at 116, 118 n.14. This unfair burden is already prompting some hospitals in high-cost states to directly employ physicians in high-premium specialties, like obstetrics and neurosurgery. Mello et al., *supra* note 65, at 230. Other hospitals are arranging for these physicians to obtain insurance from the hospital's carrier ("channeling") or are subsidizing their premiums. *Id.*

96. BAKER, *supra* note 11, at 178 (indicating reduction in expense and complexity of defending lawsuits).

97. 2 AM. LAW INST., *supra* note 24, at 119.

98. See Sara C. Charles et al., *Physicians on Trial: Self-Reported Reactions to Malpractice Trials*, 1988 W.J. MED. 358, 359 (noting that sued physicians report significant adverse symptom regardless of "whether a physician goes to trial or even whether he or she is vindicated by a favorable trial outcome").

been convicted of a felony and whether a malpractice claim has ever been brought against me. So it's OK to have been accused of murder – but not of malpractice.<sup>99</sup>

Thus, every claim, however unwarranted, becomes a part of a physician's "record." That record follows her throughout her professional life, resurfacing each time she applies for liability insurance, manage care participation, licensure, or hospital privileges.<sup>100</sup>

Exclusive hospital liability offers physicians an escape from this trap. They would not be served with legal papers. They would not be named as a party in a lawsuit. Settlements for accidents occurring in a hospital would be paid by the hospital, not an individual physician. Thus, no reports would be owed to the National Practitioner Data Bank. While some of this information is still likely to come to the attention of hospital privileges committees and liability insurers, the elimination of a formal claim against individual physicians, the elimination of responsibility for purchasing liability insurance, and the difficulty of teasing out the meaning of an enterprise liability claim lodged against a hospital by a patient treated by many individual providers seems very likely to provide an enormous emotional and professional benefit to physicians. In practice, enterprise liability places physicians in the same legal position enjoyed, as a practical matter, by point of service employees in virtually all other industries. As a political matter, the crucial question is whether physicians will see these legal, economic, and perhaps to a lesser extent, professional benefits as a sufficient *quid pro quo* for the loss of independence that physicians will experience as hospitals adopt more patient safety protocols.

### *E. Aligning Tort Law with the Other Health Care Goals*

With the adoption of enterprise liability, malpractice law would shift from being an obstacle to the modern movement for health care accountability to being a partner. Hospital enterprise liability would align malpractice law with current efforts by agencies and policymakers to reduce unnecessary health care costs and to improve quality of care. Each would do so by treating the hospital and its affiliated enterprises as the primary locus of accountability. Without this change, hidebound physicians who are loathe to cede any authority to their hospital can justify their recalcitrance by noting that tort law places the onus of accountability on them, not their hospitals. Enterprise liability will eliminate this justification.

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99. Elliott M. Perlman, *Well-Managed Case Gets Caught in Malpractice Fervor*, AM. MED. NEWS, Feb. 21, 1994, at 14.

100. *Id.*

## VI. POTENTIAL DISADVANTAGES OF ENTERPRISE LIABILITY

Like any reform proposal, exclusive enterprise liability has its own potential weaknesses. In addition, it poses problems that must be solved. However, these concerns do not justify the rejection of enterprise liability.

It is possible, for example, that the elimination of individual physician liability could dilute the incentive that physicians have to avoid patient injuries. Yet, malpractice law's deterrent signal is already badly diluted by the availability of liability insurance and by widespread belief that the civil justice system does not reward competence. As a result, the incentive that enterprise liability places on hospital systems to reduce iatrogenic injury is likely to yield more powerful and more productive pressures on individual physicians to participate in hospital safety initiatives and to reduce errors than does existing malpractice law.

A second potential difficulty associated with hospital enterprise liability will be defining the boundaries of the hospital's vicarious liability. For example, courts or legislatures adopting the new form of vicarious liability would need to decide whether injuries occurring in outpatient facilities or those caused by errors during office visits following hospitalization should be included.<sup>101</sup> However, line-drawing of this nature is a familiar and inescapable part of lawmaking. The task of determining the boundaries of hospital organizational liability should not be any more troublesome than countless other similar projects that lawmakers regularly tackle. Furthermore, about ninety percent of all malpractice claims and payments currently arise out of care given *inside* a hospital.<sup>102</sup>

*Third*, the immunity given to individual providers limits tort law's ability to achieve corrective justice. Wrongdoers will not directly compensate the persons harmed by their transgressions. That is a significant disadvantage. However, the direct link between tortfeasor and victim was weakened long ago by the rise of liability insurance, especially in the absence of experience rating.<sup>103</sup> Furthermore, enterprise liability, whether *de jure* or *de facto*, offers injured individuals an adequate *quid pro quo*. In the place of compensation from the individual wrongdoer, the plaintiff acquires a right of action against the organization that benefited from the wrongdoer's work and created the environment in which the wrongdoing occurred. In addition to this substitution, enterprise liability offers the promise of fewer future accidents. Thus, lawmakers in every state tolerate *de facto* enterprise liability in other areas of tort liability.<sup>104</sup> Furthermore, in the field of health care, there is one respect in which the adoption of enterprise liability will actually improve tort law's

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101. 2 AM. LAW INST., *supra* note 24, at 113-14.

102. *Id.* at 114.

103. See WEILER ET AL., *supra* note 31, at 147-48; Mello & Brennan, *supra* note 2, at 1626.

104. See Mello & Brennan, *supra* note 2, at 1604-06.

ability to achieve corrective justice. That will occur whenever the underlying responsibility for the patient's injuries lies as much in a poorly designed system as in an individual lapse of judgment. As a result, hospital enterprise liability seems to offer patients sufficient benefits to justify the loss of the right to sue individual tortfeasors.

The fourth objection likely to be raised against enterprise liability is that it will lead to corporate interference with medical judgment. Practicing physicians, in particular, are likely to fear the loss of autonomy inherent in greater organizational accountability. From the days of the *Darling* decision, organized physician groups have opposed the expansion of hospital vicarious liability primarily because they fear that it will lead to interference with medical decision-making by treating physicians.<sup>105</sup>

Regrettably, much of the faith that these critics place in the instincts of individual physicians is misplaced. Surprisingly few clinical practices are actually based on scientific evidence.<sup>106</sup> Moreover, many studies have found that clinical practices vary dramatically and inexplicably from one location to another. The pioneer in this field, John Wennberg, found, for example, that eight percent of the people in one Vermont community had their tonsils removed, while seventy percent of the people living in a different Vermont town had undergone the surgery.<sup>107</sup> In Iowa, rates of prostate removal ranged from fifteen percent to sixty percent.<sup>108</sup> A Medicare study found that more than half of the procedures studied had local variations of more than three hundred percent.<sup>109</sup> Yet, no medical explanation could be found for these widely different medical practices.

Researchers have also found that physicians often fail to adopt procedures which are widely agreed to be the standard of care. For example, in 1980, a major study established that rigorous glucose control significantly reduced long-term complications from diabetes.<sup>110</sup> Yet, fifteen years later, only about one of four diabetic patients was receiving the recommended

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105. 2 AM. LAW INST., *supra* note 24, at 125.

106. See E. HAAVI MORREIM, *BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS* 51 (1995) (concluding that customs are sometimes based on "habit, hunch, current fashion, and the profession's folk wisdom"); Sara Rosenbaum et al., *Who Should Determine When Health Care is Medically Necessary?*, 340 NEW ENG. J. MED. 229, 231 ("Much of medical practice is the result of tradition and collective experience. Many basic medical interventions have not been studies rigorously.").

107. John Wennberg, *Dealing with Medical Malpractice Variations: A Proposal for Action*, HEALTH AFF., Summer 1984, at 6, 9.

108. *Id.*

109. WILLIAM CURRAN ET AL., *HEALTH CARE LAW AND ETHICS* 36 (5th ed. 1988).

110. DCCT Research Group, *The Absence of Glycemic Threshold for the Development of Long-Term Complications: The Perspective of the Diabetes Control and Complications Trial*, 38 DIABETES 1289 (1989).



number of annual tests.<sup>111</sup> In another example, researchers found that only half of the patients who should be receiving beta-blockers to prevent recurrence of myocardial infarctions were receiving them. Remarkably, this study took place after the American College of Cardiology had adopted a guideline recommending their use.<sup>112</sup> Sadly, these findings are not aberrant.<sup>113</sup>

Sometimes, poor decisions seem to be driven by conflicts of interests. Researchers have found that a physician is far more likely to order a procedure like a lab test or x-ray if the physician owns the facility that will perform the procedure.<sup>114</sup> Similarly, physicians are far more likely to order an expensive procedure if it is a procedure that she can personally provide than if it is a treatment that would require a referral. For example, researchers have found that cardiologists who do invasive procedures are much more likely to recommend such procedures than are primary care physicians and cardiologists who do not perform these procedures.<sup>115</sup> Even small things can interfere with medical judgment. For example, researchers have found that physicians who are feted by pharmaceutical sales representatives are more likely to prescribe drugs sold by that company.<sup>116</sup>

Lawrence Gostin, a respected law professor and public health expert, summarized the current state of health care quality this way:

The quality of health care is, by most accounts, a serious problem. Research has demonstrated that physicians overuse health care services by employing unnecessary interventions that are costly and place patients at risk; underuse services by failing to afford standard care that would produce favorable outcomes; and misuse ser-

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111. See Lee N. Newcomer, *Physician, Measure Thyself*, HEALTH AFF., Jul-Aug. 1998, at 32, 33.

112. See *id.* (reviewing the studies). Other studies have found that rates across the country vary from five percent to ninety-two percent John E. Wennberg et al., *Geography and the Debate Over Medicare Reform*, HEALTH AFF., W99 (Feb. 13, 2002), at [http://www.healthaffairs.org/WebExclusives/Wennberg\\_Web\\_Excl\\_021302.htm](http://www.healthaffairs.org/WebExclusives/Wennberg_Web_Excl_021302.htm). Interestingly, communities typically did better on some performance measures and worse on others. *Id.*

113. See MORREIM, *supra* note 106, at 70 (reviewing the findings of failure to follow practices widely agreed to be appropriate).

114. See RICHARD P. KUSSEROW, U.S. DEP'T. OF HEALTH & HUMAN SERVS., FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES: REPORT TO CONGRESS 18 (1989) (documenting the higher incidence of treatment for patients that are referred in these circumstances). That practice was tolerated by physicians until Congress intervened. See Thomas L. Greaney, *How Many Libertarians Does it Take to Fix the Health Care System?*, 96 MICH. L. REV. 1825, 1831 (1997).

115. See John X. Ayanian et al., *Rating the Appropriateness of Coronary Angiography—Do Practicing Physicians Agree with an Expert Panel and with Each Others?*, 338 NEW ENG. J. MED. 1896, 1901 (1998).

116. See Timothy S. Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 570 (1988).

vices by devising the wrong treatment plan or improperly executing the correct plan.<sup>117</sup>

David Eddy, a highly respected physician and policy analyst, reached the same discouraging conclusion:

[G]iven the very high rates of inappropriate care that can prevail in communities, if we actually measure what practitioners were doing and used that to define the standard of care, we would run a high risk of installing an inappropriate practice as the standard of care. The well-documented overuses of hysterectomies, antibiotics, bypasses, and C-sections are examples.<sup>118</sup>

In short, medical quality could be much better. To make it materially better evidence-based practices must be implemented more uniformly across the range of clinical medicine. As a result, sensible practice guidelines and hospital oversight have an important role to play. Although we need to preserve room for the exercise of medical judgment based on the particular circumstances of each patient, the existing system of medical care unquestionably fails to take sufficient advantage of the opportunities that exist to improve patient safety by expanding the use of best practices.<sup>119</sup>

Consistent with this evidence, studies of clinical decision support systems have repeatedly found that these systems improve the medical treatments chosen by physicians.<sup>120</sup> In that context, at least, good science beats “clinical judgment.” Similar reasoning has led John Wennberg and his colleagues to recommend that care of patients with chronic severe illness be shifted from the current fragmented and disorganized environment to more organized systems that are accountable for their costs and their outcomes.<sup>121</sup> They concluded that the care provided by integrated systems is superior because it more often squares with sound clinical science.<sup>122</sup>

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117. Lawrence O. Gostin, *A Public Health Approach to Reducing Error: Medical Malpractice as a Barrier*, 282 JAMA 1742-43 (2000).

118. David M. Eddy, *The Use of Evidence and Cost Effectiveness by the Courts: How Can It Help Improve Health Care?*, 26 J. HEALTH, POL., POL'Y & L. 387, 396 (2001).

119. See Fisher et al., *supra* note 1, at W54 (noting that traditional physicians autonomy separates individual physicians from responsibility for system outcomes).

120. Kachalla et al., *supra* note 53, at 203. Researchers have had more difficulty designing algorithms and implementation systems for *diagnosis* because “workflow impediments and efficiency concerns” have limited both system effectiveness and department willingness to adopt the systems. *Id.*

121. See John E. Wennberg et al., *Extending the P4P Agenda, Part 2: How Medicare Can Reduce Waste and Improve the Care of the Chronically Ill*, 26 HEALTH AFFAIRS 1575, 1579 (2007).

122. See *id.* at 1577.

Yet, studies indicate that physicians resist the modern tools of quality improvement such as outcome reviews, data sharing, and collective design of safer systems.<sup>123</sup> At present, tort law gives them little incentive to abandon their recalcitrance. As William Sage suggests, “American medicine remains the world’s most expensive cottage industry, resisting all efforts to achieve efficient scale and scope if they suggest government or corporate control.”<sup>124</sup> The effort to preserve this cottage industry “evokes a health care world that has long since passed.”<sup>125</sup>

Fortunately, some trends in health care delivery may reduce physician resistance to hospital-wide quality improvement initiatives. Physicians are reportedly less willing than in the past to take emergency department calls or follow their patients while in the hospital.<sup>126</sup> As a result, hospitals are hiring full-time hospital-based physicians to assume these responsibilities. The doctors who take these jobs are likely to treat the hospital’s assumption of legal liability as a fringe benefit, rather than a threat, just as residents do. As Tom Baker notes, enterprise liability has existed in university hospitals and staff-model health maintenance organizations for many years without revolt.<sup>127</sup> The members of this new generation of “hospitalists” are more likely than their predecessors to identify their success with that of the hospital. As a result, they are likely to embrace the adoption of sensible quality improvement plans that would, nonetheless, have ruffled the feathers of community-based physicians.

It is time for malpractice law to adapt to the modern era of health care delivery.<sup>128</sup> The law’s delay in adapting to the modern era has been bad for both physicians and patients. Physicians have been kept on the front line of malpractice litigation. Anyone who works in health law knows how demoralized they are. At the same time, nineteenth century malpractice law deprives patients of the safety systems that enterprise liability would encourage. From hand washing in the OR to beta blockers in the ER, system-wide initiatives can save lives and preserve limbs. Enterprise liability is the contribution that tort law can make toward realizing that potential.

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123. Anne-Marie J. Audet et al., *Measure, Learn, and Improve: Physicians’ Involvement in Quality Improvement*, 24 HEALTH AFF. 843, 850 (2005); see also Michael D. Cabana et al., *Why Don’t Physicians Follow Clinical Practice Guidelines? A Framework for Improvement*, 282 JAMA 1458, 1458 (1999); Arnold Milstein & Nancy E. Adler, *Out of Sight, Out of Mind: Why Doesn’t Widespread Clinical Quality Failure Command Our Attention?*, 22 HEALTH AFF. 119, 124 (2003).

124. William M. Sage, *Legislating Delivery System Reform: A 30,000 Foot View of the 800-Pound Gorilla*, 16 HEALTH AFF. 1553, 1553 (2007).

125. 2 AM. LAW INST., *supra* note 24, at 125.

126. Fisher et al., *supra* note 1, at W54.

127. BAKER, *supra* note 11, at 177.

128. 2 AM. LAW INST., *supra* note 24, at 126.

## VII. CONCLUSION

The most important reason to favor enterprise liability is the powerful incentive that it will deliver to hospital systems to reduce medical mishaps. In this important respect, hospital enterprise liability is far superior to the traditional rules of malpractice liability, which emphasize individual legal liability over organizational liability. There is no systematic evidence that the traditional rules of malpractice liability make patients safer. Perhaps that should not come as a complete surprise since hospitals currently lack the same legal incentive to minimize accidents that other businesses, like airlines and auto manufacturers, have. Surely, patients deserve the same protections as airline passengers and auto drivers.

Exclusive hospital enterprise liability has the potential to revive the dormant deterrent power of tort law. Unlike individual physicians, hospitals are experience-rated repeat players. They also possess both the system-wide vantage point needed to identify the high-risk stages of the health care delivery process and the resources and authority needed to implement systematic improvements. Adoption of exclusive enterprise liability could produce still more improvements in patient safety if it increases the willingness of physicians to discuss errors and near misses openly and to participate in patient safety initiatives.

In addition, adoption of enterprise liability would align the incentives of tort law with the goals of modern patient safety advocates, who emphasize the need to shift our focus from the blaming of individual wrongdoers to the design of systems that anticipate and prevent human error. Right now, physicians who are lukewarm about the shift in responsibility from individuals to systems can justify their recalcitrance by citing tort law's placement of primarily legal accountability on them, rather than their hospitals. Enterprise liability would change that.

Exclusive enterprise liability would also shift legal responsibility onto actors who are better situated to weather the inevitable and recurrent insurance cycles, spare high-risk specialists from shouldering a disproportionate share of health care's liability costs, reduce litigation costs by consolidating the defense of the hospital with the defense of its individual providers, and dampen the extraordinary fear and anger of practicing physicians. Those emotions often interfere with the relationship between a physician and her patient, especially when mishaps occur, and they clearly fuel physician reluctance to discuss errors openly. Sadly, physician anger seems to intensify with each loop of the insurance cycle.

Over the past thirty years, the substantial benefits associated with enterprise liability have prompted many health law scholars to favor its adoption. In the past, however, they had few allies in the health care community. That has changed. During the past two decades, a patient safety movement has arisen. More importantly, leaders in that movement believe strongly in shifting the focus of quality improvement efforts away from the blaming of individuals and toward the improvement of processes by which complex modern

health care is delivered. Moreover, they are not alone. Health policy experts with a market orientation are trying to improve the quality and cost-effectiveness of health care through the identification and reward of superior performance. Like the patient safety advocates, they emphasize greater attention to organizational outcomes.

The contrast with traditional malpractice law is stark. Existing malpractice law places its principal onus on individuals who (we now know) are unlikely to change their behavior in productive ways to avoid liability. Even if they were able to read the deterrent signal accurately, they would lack the power or resources needed to effectuate systematic change. At the same time, these individuals are poorly situated to endure the periodic spikes of the liability insurance cycle. All of this makes them so angry that they are obsessed with tort reform—even reforms that are harsh and unfair to their own patients. In short, we have managed to create a system that combines the worst of all worlds.

Every week, patient safety researchers produce new insights about the ways in which medical errors could be reduced. Yet, our legal system clings to a model that minimizes the probability that these insights will be put into practice.

Patient safety advocates have long stressed the importance of recognizing the inevitability of human mistakes. Thus, they call for less emphasis on blaming individuals and more attention to building better systems. Unfortunately, they have yet to appreciate how much enterprise liability would aid their efforts. By acting together, however, advocates of enterprise liability and crusaders for patient safety can insure that enterprise liability receives the attention that it deserves from policy makers.

To generate political traction, enterprise liability will probably need to receive a better reception from physicians than it has in the past. That may be possible. Exclusive enterprise liability constitutes a very attractive alternative to the current rules of malpractice liability. The more upset that physicians become with individual liability, the more appealing exclusive enterprise liability will be. The benefits to them would be huge. One of the most important would be the improvement of their relationship with their patients, especially when bad outcomes occur. Enterprise liability would allow them to see their patients as persons, once again, rather than as plaintiffs. It might even convert some physicians from being bitter skeptics of programs like “Sorry works” into being fans. These programs encourage providers to be honest with their patients about adverse outcomes and help focus their energies on helping their patients get back on their feet, rather than exercising their right to remain silent and treating those patients as pariahs. Surely, this would be a better environment in which to practice medicine than the one physicians currently inhabit, even if the new order comes with a few more practice protocols.

Despite its absence from high level national debates about health care reform, the case for exclusive hospital liability is stronger than it has ever been. The rise of the patient safety and accountability movements has not

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only created a group of potential supporters, but has also given markedly greater credibility to the claim that systemic oversight is crucial to major improvements in patient quality. The emphasis of these safety experts on organizational accountability powerfully supports the logic of making hospitals legally responsible for medical errors that occur on the premises. The time has come for state-by-state experiments with hospital enterprise liability.

